Associated Plastic Surgeons & Consultants, P.C.
Cosmetic & Reconstructive Plastic Surgery
• Diplomates American Board of Plastic Surgery
864 West Jericho Turnpike
West Hills, New York 11743
Tel: 631-423-1000
• Fax: 631-271-6900

Signature on File

I hereby authorize:

- use of this form on all my insurance submissions
- release of information to all my Insurance Companies
- my doctor to act as my agent in helping me obtain payment from my Insurance Companies
- payment direct to my doctor
- that a copy of this form be used in place of the original

Guarantee of Payment

Many insurance companies, including managed care organizations, require prior written authorization for treatment and follow-up visits It is your responsibility as a patient to obtain all necessary authorizations from your insurance company prior to receiving medical services. If you have not received prior approval for the service or authorization has been denied, you are fully responsible for all charges if your insurance company does not agree to pay. In addition, you will be responsible for all deductibles, co-insurance, and co-payments, any service that is not covered by your insurance plan, and any service that your insurance company has determined not to be "medically necessary."

I have read and understand this information. I understand that my insurance company may deny coverage. Therefore, I authorize Associated Plastic Surgeons & Consultants, PC (APS) to perform medical services on my behalf. I agree to be fully responsible for all charges. I understand that APS is relying on this promise and is rendering services without requiring payment at the time of service based on such reliance.

HIPAA

I have been given the opportunity to read the above regulations a copy of which is on file at the front desk or with the office manager.

Permission is granted for Associated Plastic Surgeons & Consultants to speak to the following individual(s) about my treatment. This permission will continue until it is revoked in writing.

_____

_____

By my signature below, I agree to all items (Signature on File, Guarantee of Payment and HIPAA outlined above.

_____ _____

Signature Date

_____

(Please Print Name)